OTHER HEALTH INSURANCE

SECTION J

Employer Group Health Plans

Special Enrollment Period (age 65 and still working)

This period is available if you are eligible for Medicare and wait to enroll in Medicare Part B because you or your spouse were working and had group coverage through the employer or union. You can sign up for Part B anytime you are still covered by the employer or union health plan, or during the 8 month Special Enrollment period following the month your employer or union coverage ends, or when the employment ends (whichever is first).

Note: Employers are the group health plan policyholders. As long as they do not violate discrimination laws, they are not legally restricted from discontinuing the policy, increasing premiums, altering the plan coverage or excluding employees who are in certain categories (i.e. age 65 or older). They can convert your group health plan to another plan; for example a Medicare Supplement policy. In fact, conversion to a group supplement plan along with your Medicare may offer you more coverage than having your combination of Medicare and Medigap plan.

After retirement Medicare becomes the primary payer. If the group health plan is continued after retirement, the group health plan is the secondary payer.

Group Health Plan for Retirees - Continuation or Conversion
Retired workers age 65 or older may or may not be continued under an employer group plan for coverage secondary to Medicare. Some employers offer continuation or conversion of the health insurance as a retirement benefit. This allows retirees to continue the group coverage or covert to an individual plan.

Continued group plans are not subject to federal and state minimum standards for Medicare Supplement Policies.

Conversion of the group plan to an individual plan means the individual plan is subject to government minimum standards. It would be a standardized Medigap policy. The conversion can be paid by you or the employer.

Questions You Might Ask

- Is the employer stable? Is the plan likely to be terminated due to financial pressures?
- Does the plan have a lifetime maximum benefit?
- What will the plan pay if you have Medicare?
- Does the plan act as a supplement to Medicare; does it coordinate benefits?
- How is the plan affected by guarantee issue provisions?

Carve Out Employer Group Plans

The employer group policy may "carve out" or "wrap around" Medicare. Another phrase used is "integrate." Medicare and the group plan may both cover a particular treatment; however when one pays, the other does not. A group plan may pay for some services that are not covered by Medicare.

Employer group plans can be misunderstood and may not act as a Medicare supplement policy. This means that your group plan does not normally pay for Medicare co-pays and deductibles. You may have an option to convert your group plan to a Medigap policy. Read your plan carefully to see how you plan "fills in" Medicare gaps. Copies of your plan or information about plan coverage can usually be obtained by calling the employer's benefits coordinator.

Options for a Spouse Under 65 and Losing a Group Plan

Many employers have terminated health coverage for retirees leaving them and their spouses without medical coverage. Medicare, unlike most employers group plans, covers only you, if you qualify. There are no provisions for your dependents. Some options to consider:

- Try the employer. Sometimes they will continue coverage for your spouse. You may have to pay part or all of the premium.

- COBRA - You only have 60 days to agree to keep coverage under COBRA. You will pay the entire premium plus a 2% administrative fee.

- Private health plan. If your spouse is in good health, you may be able to purchase a policy until he/she qualifies for Medicare.

- Would the employer group plan allow the spouse to convert to an individual plan?

- Seek employment that offers health insurance benefits.

- If rejected by insurance companies due to health, Indiana Comprehensive Health Insurance Association (ICHIA) may be an option. These policies are usually expensive due to the nature of the risks for the insuring company.

COBRA
(Consolidated Omnibus Budget Reconciliation Act-1985)

COBRA is a **temporary extension** of your employer's group health coverage insurance. You must **apply within 60 days** of a specific qualifying event or you will lose your right to extend your group coverage under COBRA. The employer must notify the plan's administrator within 30 days of the qualifying event. The plan administrator must send you a COBRA election notice within 14 days of receiving notification. To sign up, you should talk to the employer's benefits or human services division. **COBRA can help you if you are under 65 and disabled and qualify. You may find it difficult to buy other health care insurance.**

The employee and their dependent beneficiaries **must be offered the same health insurance benefits** with the same deductibles and benefit limits that they were receiving before the COBRA qualifying event.

You are eligible if:

- The employer has 20 or more employees.
- The employee has worked at least half of working days in the previous year.
- The employee is covered by the group health plan and you are in the employer group health plan on the day before the employee has a "**qualifying event**". (A specific event that causes you to lose employer group health care coverage).

Qualifying Event	Who's Eligible	Length of Eligibility
Voluntary or involuntary termination of employment/reduction of work hours (other than for "gross misconduct)	Employee Spouse Dependent Child	18 Months
Employee enrolls in Medicare Part A or B	Spouse Dependent Child	36 Months
Employee & covered individual divorce	Spouse Dependent Child	36 Months
Employee dies	Spouse Dependent Child	36 Months
Loss of dependent child status	Dependent Child	36 Months

Under COBRA you will be paying the entire premium for coverage plus a 2% administrative charge. While this can be expensive, **compare the total cost and benefits** of COBRA coverage with the total cost and benefits of other options (including Original Medicare, Medicare Advantage Plans, Medigap policies, ICHIA, and private health care insurance) to determine what will best suit your finances and health needs. Be sure to compare:

- Prescription coverage
- Eye, dental, foot, and other coverage
- Maximum benefit limits (annual & specific types of care)
- Co-pay amounts
- Yearly deductibles

Cobra and Social Security Disability Benefits

The employer group health insurance extends for 18, 29, or 36 months, (depending on qualifying event). If you qualify for Social Security disability benefits, special rules apply to extend the 18 months of COBRA coverage to **29 months.** To receive this special coverage extension, you must notify the former employer insurance division within 60 days of receiving your disability determination.

You pay the entire premium, plus a 2% administrative charge to the continued group health plan for the first 18 months. If your disability

(continued next page)

started before your COBRA qualifying event, your group coverage could be extended to 29 months. **For the last 11 months, your premium will increase to 150% of the original premium**. If you enroll in Medicare Part A or Part B after already being on COBRA, your COBRA coverage will end.

Special Note: **If you have Medicare prior to the qualifying event, you must be offered COBRA coverage.**

For more information about COBRA, call the SHIP State Office and ask for a COBRA brochure, or call the Department of Labor for COBRA questions, 1-202-219-8784 or 1-202-219-8776. **To learn more about how to apply for Social Security or Medicare benefits, call 1-800-772-1213 (for hearing impaired, TTY: 1-800-325-0778) or visit their website at www.ssa.gov.**

Public Programs

Railroad Retirees

If you are a railroad retiree, you must apply to the Railroad Retirement Board instead of the Social Security Office to sign up for Medicare. Medicare benefits are the same, but claims are processed differently.

- Part A claims are processed by Palmetto GBA.
- Part B claims are processed by United Healthcare.

TRICARE For Life (formerly CHAMPUS)

TRICARE For Life (TFL) is a health insurance plan offered through the Department of Defense for active and retired military personnel and qualified family. TFL is for all TRICARE beneficiaries who are eligible for Medicare because of disability, ESRD or age. Like Medicare, TFL is designed to cover health care for injuries and illnesses. TFL will generally cover the same services that Medicare covers.

TRICARE beneficiaries, upon attaining the age of 65 and becoming entitled to Medicare Part B, will transfer from TRICARE to TRICARE For Life. TFL will pay secondary to Medicare, beginning the first day of the first month you turn 65.

To be eligible for TFL you must be one of the following:

- Medicare eligible uniformed service retirees, including retired Guard and Reservists;
- Medicare eligible family members, including widows/widowers; or
- Medicare eligible un-remarried former spouses, if they were eligible for TRICARE before age 65
- Dependent parent and parent-in-laws are not eligible for TFL.

TFL pays in general like a Medigap policy -

- Medicare deductibles, coinsurance and co-payments
- First three pints of blood each year

    - 80% of costs at TFL network
    - for inpatient hospital care from day 151
    - skilled nursing facilities (SNF) from day 101
- 75% of costs at non-TRICARE network from day 151 for hospital, or day 101 for SNF.

Who Pays First?

- For services payable by both Medicare and TFL, Medicare will pay first and the remaining out-of-pocket expenses will be paid by TFL.

- For services payable by TFL, but not Medicare, TFL will pay the same as if you were age 65. you will be responsible for the TFL annual deductible and costs shares.

- For services payable by Medicare, but not TFL, Medicare will pay as usual, TFL will pay nothing. You will be responsible for Medicare deductibles and co-pays.

- For services not payable by TFL or Medicare, you are responsible for the full medical costs.

The Defense Eligibility Reporting System notifies you within 90 days prior to your 65th birthday that your benefits are about to change. You are expected to contact your nearest SSA Office to enroll in Medicare. It is important to remember that you must elect to enroll in Medicare Part B in order to be eligible for TFL benefits. If you are older then age 65 and have only Part A, you can enroll in Part B during the General Enrollment Period (January 1 through March 31).

For more information about veterans benefits please contact your Indiana Veterans County Service Officer, or the Indiana Department of Veterans Affairs office by phone (317) 232-3910, toll free call 1-800-400-4520; or online at www.in.gov/veteran.

VA Benefits for Non-active and Non-Retired Veterans

If you have or can get both Medicare and Veterans benefits, you may choose to receive treatments under either program.

In October 1996, the Veterans' Health Care Eligibility Reform Act paved the way for the creation of a Medical Benefits Package for honorably discharged veterans, based on a Priority Group Basis. This system assigns each enrolling veteran a Priority Group (ranging from 1 to 7) based on the percentage of service connected disability, former POW status, severity of needs and/or their ability to pay.

Medicare cannot pay for services you receive from VA hospitals or other VA facilities, or when the VA pays for VA authorized services you receive at a non-VA facility or from a non-VA physician. As a veteran you may be able to fill your prescriptions at your VA pharmacy, even when Medicare is paying for other services. Call 1-800-827-1000, or visit http://www.va.gov

Widows or Widowers

Veterans' benefits are also available to widows of veterans who were eligible for VA benefits, including the state VA Veteran's Home (long term care facility).

State of Indiana Retired Employees

State employee retirees may purchase various health plan. If you are a State retiree and want more information, contact your former department or employing agency, or the health insurance carrier if you continued coverage .

RIPEA (Retired Indiana Public Employees Assoc.)

RIPEA provides one insurance option for retired state government employees. For retirees on Medicare, RIPEA offers a plan to supplement Medicare. You can buy additional benefits. RIPEA is a not-for-profit corporation created by the Indiana Legislature in 1972. Eligibility requirements :

- You must be an Indiana state retiree, receiving a monthly check from PERF (Public Employers' Retirement Fund).
- You must pay the annual membership dues.

For more information call 1-800-345-9214, or online at www.ripea.org

Federal Employees - NARFE

Retired federal employees become eligible for Medicare at age 65. The Federal Employee Health Benefit Plan (FEHBP) then becomes secondary payer. There are several plans from which to choose. You may change carriers once a year during "open season." Specific information for retirees' health benefits may be obtained through the administrative office of the former employing branch of the federal government.

Teachers - ISTRF (Indiana State Teachers' Retirement Fund)

Upon retirement as an Indiana teacher, if you are eligible, you may enroll in the Anthem Blue Cross and Blue Shield health care plan. To qualify you must be a retired Indiana teacher, and a member of the Indiana State Teachers' Retirement Fund.

To see if you qualify for this coverage or for details on specific covered services, contact the Teacher's Retirement Fund at 1-800-382-4037, or online at www.ista-in.org.

ICHIA

The Indiana Comprehensive Health Insurance Association (ICHIA) is Indiana's state high risk pool plan and provides health insurance for Indiana residents who cannot obtain coverage due to health reasons. Coverage is guaranteed if you meet the eligibility requirements, but expect to pay high premiums.

ICHIA may be a good option for individuals under 65/disabled who have high drug costs, or who have been denied health insurance coverage. To be eligible for ICHIA, you must be under 65, a resident of Indiana, not eligible for Medicaid, and:

- Have been denied coverage by an insurance company;
- Had restrictions placed on coverage;
- Are unable to get an insurance plan with a premium/coverage similar to ICHIA; or
- Have been diagnosed with certain illnesses. (36 chronic, catastrophic, life-threatening diseases such as ESRD)

If you are **65 or older** and eligible for Medicare, you can not get ICHIA insurance.

ICHIA Benefits

ICHIA works through a Preferred Provider Network (PPN). If you go outside the network, benefits will usually be reduced. (Unless you are a Medicare beneficiary). Typically ICHIA will pay 80% of in network approved costs and 60% of out of network approved costs.

There are four plan options available:

Plan Option	Deductible	Out-of-Pocket Maximum*
Plan 1	$500	$1,500
Plan 3A	$1,000	$3,000
Plan 3B	$1,500	$4,000
Plan 4	$2,500	$5,000

* including the deductible and coinsurance

After meeting a deductible which can vary from $500 to $2,500 per year, you are only responsible for coinsurance amounts. Once you reach your annual out-of-pocket maximum (deductibles plus co-insurance) the plan will pay 100% of the allowable expenses for the remainder of the calendar year.

Monthly premium rates vary with age, gender, geographic location, and chosen plan. Monthly rates can range from $112-$825. Medicare beneficiaries under age 65 and disabled do not pay higher premiums due to their disability. Preexisting conditions could be excluded for up to 3 months, if you do not have prior health insurance coverage. **Prescription Drug benefits have a separate deductible** from other ICHIA medical benefits. **Medicare beneficiaries should enroll in a Medicare Prescription Drug Plan (Part D).** By enrolling in a Part D plan, Medicare beneficiaries should see a savings in their ICHIA premium.

Dependent Eligibility

Coverage for your spouse and/or dependent children is available. Your children may be eligible for coverage if they meet one of the following criteria:

- Unmarried and under 19 years of age;
- Dependent, unmarried, full time student (up to age 25); or
- Dependent Disabled Adult Child, regardless of age.

Newborns are automatically covered for the first 31 days, after that they will need to be added as an additional dependent and the monthly premium adjusted.

Medicare and ICHIA

After the ICHIA plan deductible is met, ICHIA will usually pay Medicare co-pays and deductibles at 80%. ICHIA may pay 80% of claims that Medicare denies (may pay only 60% if out of network). Individuals who are 65 or older and eligible for Medicare cannot get insurance coverage through ICHIA.

Contact **ICHIA Customer Service -1-800-552-7921**, P. O. BOX 33730, Indianapolis, IN 46203-0730. Or you can apply online at: **www.onlinehealthplan.com** Sign on as a guest, and then select Indiana Comprehensive Health Insurance Association (ICHIA).

Private Programs

Hospital Indemnity Insurance

These policies are not designed to act as Medigap policies. They pay a fixed amount for specified time periods that you are hospitalized. Payments are usually made directly to you. Amounts and requirements are stated in each policy and vary from company to company. These plans may fail to keep pace with inflation and rising hospital costs.

Major Medical Insurance Plans

Cover major medical expenses for high cost illnesses. These plans usually have a high deductible but may pay very large total payments. They have limited availability to people over age 65, unless you are continued under an employer group health plan. Major Medical plans are rarely sold as individual policies.

Specific Disease Insurance

At times these are called “dread disease” policies. They pay benefits for the diseases are named in the policy (i.e. cancer). They usually pay either a fixed amount for each type of treatment, or reimburse for expenses up to a fixed amount for each type of treatment. Coverage generally does not keep pace with inflation. Benefits are not designed to fill gaps in Medicare.

Personal Expense Policies

These policies are marketed to seniors along with Medigap plans. They are not Medigap policies. These policies provide some coverage for routine physical, dental, vision and hearing exams. These exams are not covered by Medicare. Some coverage is also available towards the cost of eyeglasses and hearing aids. There are limits as to the amounts of coverage per services, as well as limits to how often services may be received.

Filing for Benefits

Patients with private health insurance are responsible for filing any claims for benefits received under the terms of their policy. All Medicare claims must be submitted by the Physician or other service provider, even when Medicare assignment is not accepted.

A Quick Look: Know Who Pays First if You Have Other Health Insurance Coverage

If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers so your bills can be sent to the appropriate payer to avoid delays. Some of the most common situations where Medicare can pay second are listed below; however, this chart does not cover every situation.

If you. . .	Condition	Pays First	Pays Second
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age.	The employer has less than 20 employees The employer has 20 or more employees	Medicare Group Health Plan	Group Health Plan Medicare
Have an employer retiree plan and are age 65 or older, or are disabled age 65 or older.	Eligible for Medicare	Medicare	Retiree Coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working.	The employer has less than 100 employees Employer has 100 or more employees	Medicare Group Health Plan	Group Health Plan Medicare
Have End-Stage-Renal-Disease (permanent kidney failure) and group health plan coverage (including retirement plan).	First 30 months of eligibility or entitlement to Medicare After 30 months	Group Health Plan Medicare	Medicare Group Health Plan
Are covered under worker's compensation because of a job related illness or injury.	Eligible for Medicare	Worker's compensation related service	Medicare
Have Black Lung disease and covered under the Federal Black Lung Program.	Eligible for Federal Black Lung Program	Federal Black Lung Program for Black Lung related services	Medicare
Have been in an accident where no-fault or liability insurance is involved.	Eligible for Medicare	No-fault Liability insurance for accident related services	Medicare
Are age 65 or older, or disabled and covered by Medicare and COBRA.	Eligible for Medicare	Medicare	COBRA